

## HISTORY: General Psychiatric History

*This is a catchall formula for when you are not given much in advance regarding your patient, and have a short time to collect information. The below guide skips some of the more condition-specific material, but will show an examiner that you have a good understanding of the broad areas of mental disorder and can go some way towards forming a risk assessment. Remember to leave time to summarise at the end, and formulate a plan. An examiner will often ask you "is this person safe enough to go home?" or "what follow up do you think this person needs?" Some answers to this are explored below.*

*Sample vignette: "You are an F2 on a GP placement. Mr X is a 59 year old gentleman who has been brought to the surgery by his daughter because of his strange behaviour."*

### Body language

Remember to address body language and behaviours directly. Role players in psychiatry stations will give pointers by the way they act/what they are wearing. Show the examiner that you are considering this by asking questions head on: a person who is looking suspiciously around them may be responding to auditory hallucinations – ask "you're looking around you quite a lot; is there something you can hear?"

### Introduction

- "My name is...I'm one of the doctors with the practice, what brings you to the surgery today?"
- Then focus on the areas below, being guided by what the patient says.

### Screen for psychotic symptoms

- Ever hear/see things that other people can't hear/see? (*hallucinations*)
- Has anyone been interfering with your thoughts? (*thought disorders*)
- Is anyone out to get you? (*paranoid delusions*)
- Do you believe you have any special powers? (*grandiose delusions*)
- Could there be any other explanation for this? (testing *insight*)

### Screen for core affective symptoms and duration

- What is your mood like (can ask for a score out of 10)? *low mood*
- What are your energy levels like? *anergia*
- Do you still enjoy things that you used to? *anhedonia*
- How is your sleep? *insomnia/hypersomnolence*
- What's your appetite like? *weight loss*
- What is your concentration like? *poor attention/irritability*
- How long has this all been going on? *2 weeks of one major+minor symptoms*
- Can you remember a time that you didn't feel like this? *insight*
- This may also be a good time to test for *risk* – Have you thought about what might happen if things were to continue like this? Have you made any plans to harm yourself, or even take your own life?"

Depression (DSM V): One of the below...	Plus four or more of these for >2 weeks
2 weeks or more of: Depressed mood, most of the day, nearly every day Loss of interest of pleasure	Unintentional weight loss, or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness, diminished concentration, recurrent thoughts of death or suicide.

### Screen for Anxiety Spectrum Disorders

- Would you describe yourself as a worrier? *GAD/phobia/social phobia*
- Is there anything in particular you worry about? *Phobia/PTSD*
- Do you find yourself avoiding social situations, or large groups? *GAD/agoraphobia*
- Have you had any difficulties leaving the house? *Agoraphobia/OCD*
- Are there certain things that you must do before you leave the house? *OCD*
- How often do you wash your hands a day? *OCD*
- Is there something that happened that kick-started all of this? *PTSD*
- Do you sometimes have thoughts that you feel you just can't get rid of or pop up in your mind without you wanting them? *OCD/PTSD*

### Screen for alcohol/substance mis-use

- It sounds like things have been really tough for you lately; what are you doing to help you cope?
- Lots of people find that they drink a lot more/start using other substances like drugs to help them through the toughest of times, is that something you are doing?
- Tell me about an average day, *salience*, *withdrawal*, *narrowing of repertoire*
- What sort of thing are you taking; are you finding that you are taking more and more? *Narrowing of repertoire/tolerance*
- Would you say that it is the most important thing to you at the moment? *salience*
- What happens when you stop? *withdrawal*
- *CAGE* (for *alcohol*): this is a validated tool that screens for alcohol mis-use

### Empathy

This is one of the most difficult things to get right in a psychiatric history. It is not your job to agree with a patient's delusions, or substance mis-use problems, but it is important to react sensitively to them. Avoid saying things that belittle patient's experiences such as "I know how you feel" or directly comforting them with platitudes, but do validate their experiences with open phrases that echo what you have been listening to: "It sounds as though you've been through a tough time," or "I'm hearing that you've had pressure from lots of areas in your life."

### Substance abuse

Be specific when taking alcohol/drug histories. Ask for a quantification and avoid allowing your patient to be vague about how much they drink. "Three drinks" might mean three small glasses of wine, or three 2L bottles of super-strength cider. Know your unit quantities!

### CAGE History

**Have you ever thought about Cutting down?**

**Do you ever get Annoyed when others criticise your drinking?**

**Have you ever felt Guilty about your drinking habits?**

**Do you ever start the day with a drink as an Eye-opener?**

**Previous psychiatric history**

- Have you ever seen anyone from mental health services before? This is particularly useful to see if patients have a key worker, or any ongoing involvement from a community team, which will be important in formulating your plan.
- If there is a past psychiatric history it will also be important to check medication compliance and any community treatment orders in place.

**Previous medical history**

- It is important to exclude organic disorder in a psychiatric history. It is unlikely that you will be asked to do this in a short station, but good to show you are thinking of mental disorder in the broader diagnostic context.

**Excluding organic disorders**

- TSH *hyper/hypothyroidism*
- U+Es *electrolyte imbalances*
- B12/ Folate *deficiency psychosis*
- Syphilis screen
- Urine drug screen
- FBC/CRP/ESR  
*infective/inflammatory*
- CT/MRI head  
*trauma/neoplasm/infection*
- LP *infection/inflammation*

A careful history to cover medications such as steroids or exposure to heavy metals *reactive psychosis*

**Quantify risk**

- The history should culminate in this; but you can address it sooner if you feel there is an appropriate opening (such as in assessing for mood etc).
- Remember to consider risk:
  - To self (e.g. self-harm/suicide due to depression)
  - To others (e.g. harm to others due to paranoid delusions/disinhibition)
  - From others (e.g. exploitation of finances during manic episode)
- These areas of risk can be classified into three levels
  - High – immediate risk that needs immediate attention today. This will likely spark a need for admission.
  - Medium – for example someone who has had fairly specific ideation regarding suicide, but who is otherwise well-supported in the community by family, or an involved key worker
  - Low – for example someone who presents with the symptoms of a mild depression without specific suicidal ideation, who is otherwise well-supported
- When you have identified the main risks, you should then consider your plan.

**Come up with a summary/plan**

- The examiner may ask you a specific question, such as “do you think this patient needs admission?” or otherwise. If they do not, thank the patient and say that you’d like to discuss things further with your colleague (the examiner).
- A brief summary is helpful. *“Mr X is a 59 year old man, who presents with symptoms consistent with severe depression with psychotic features. He has made specific plans to end his own life by taking an overdose of paracetamol. I am particularly concerned that he has written a note and closed his bank accounts. He still has the same stressors present in his life and states that he may go through with the attempt if he is allowed home. His risk profile is high, and I would therefore like to discuss an informal admission to an inpatient unit, and if not may need to explore a section with one of my seniors.”*
- Depending on the brief, you should make a recommendation on what you’d like to do next. Options for a plan may be:

- *Admission*: If you think the patient's risk profile is high, then you may want to recommend an admission. This can be *formal* (i.e. under section), or *informal* (i.e. a patient voluntarily agrees to come into an inpatient ward). An informal section represents a shared decision, and can always become a formal admission if the patient's risk profile changes, so this is often a good first point of call.
- *Crisis Team* – this is a community team who deal with high risk patients who can be safely managed at home, such as those who present a low suicide risk and who have family or other support mechanisms to protect them while they are plugged into community services. These teams can liaise with inpatient units for admission if the situation deteriorates.
- *Early Intervention Services* – increasingly common, these teams provide relatively quick community assessments and treatment interactions for people with suspected psychotic episodes. Again, they can liaise with inpatient units for admission if the situation deteriorates.
- *Home Treatment Team* – this is a slightly less acute community service, which would be useful to mention if someone is already known to psychiatry services.
- *Crisis House*: often used as a step down from inpatient wards, this is a supported, residential environment where medium-risk patients can stay voluntarily, usually for days to a couple of weeks.
- *IAPT (Improving Access to Psychological Therapies)* – for low risk patients, who are having trouble with mood, or anxiety spectrum disorders. Community service (generally with long waiting lists, so don't think of this if an acute problem!), that patients can refer themselves to, or via GP/other health provider. Uses psychological therapies such as CBT.
- *GP follow up* – again, for very low risk patients, for patients to explore onward referrals to community teams etc.

### Know your Sections!

The Mental Health Act Sections that you may be expected to know about as an undergraduate/junior doctor are as follows:

- Section 2: Mandates for admission to hospital for *assessment*. Lasts for up to 28 days, and must be approved by two specialist "section approved" doctors. Can be challenged within 14 days by patient via a specialist tribunal.
- Section 3: Mandates for a stay in hospital for *treatment*. Lasts for up to 6 months and must be approved by two specialist "section approved" doctors. Can be challenged once during the section (and after each time it is renewed, if applicable) via a specialist tribunal.
- Section 5(2): Mandates for keeping a patient in a general hospital by a doctor (of any grade/speciality). Lasts for up to 72 hours whilst awaiting assessment by an approved mental health practitioner (AMHP). Not renewable and cannot be challenged.
- Section 5(4): Mandates for keeping a patient in a general hospital by a nurse. Lasts for up to 6 hours whilst awaiting assessment by an approved mental health practitioner (AMHP). Not renewable and cannot be challenged.
- Section 135: Mandates for the removal of a person at risk to a 'place of safety' (i.e. hospital) from any premises (i.e. their own home). Needs one doctor and a member of police force. Lasts for 72 hours.
- Section 136: Mandates for the removal of a person at risk to a 'place of safety' (i.e. hospital) from a public place. Needs one doctor and a member of police force. Lasts for 72 hours.